CHATTANOOGA, TENNESSES 37401 $\mathbb{A}^{1/2}$ D D $\mathbb{B}^{1/2}$

1750 Chestnut Street Tower II

June 1, 1982

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Mr. James P. O'Reilly, Director U.S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region II 101 Marietta Street, Suite 3100 Atlanta, Georgia 30303

Dear Mr. O'Reilly:

TENNESSEE VALLEY AUTHORITY - BROWNS FERRY NUCLEAR PLANT UNIT 1 - DOCKET NO. 50-259 - FACILITY OPERATING LICENSE DPR-33 - REPORTABLE OCCURRENCE REPORT BFRO-50-259/80031 - REVISION 1

The enclosed report is a supplement to J. R. Calhoun's letter to you dated May 14, 1980, concerning an electrical fault on the normal feeder to 480-volt shutdown board 1B which caused loss of power to 480-volt shutdown board 1B during a 4-kV shutdown bus 2 transfer. This report is submitted in accordance with Browns Ferry unit 1 Technical Specification 6.7.2.b(2).

Very truly yours,

TENNESSEE VALLEY AUTHORITY

Director of Nuclear Power

Enclosure cc (Enclosure):

> Document Control Desk U.S. Nuclear Regulatory Commission Washington, DC 20555

Records Center Institute of Nuclear Power Operations 1820 Water Place Atlanta, Georgia 30339

NRC Inspector, Browns Ferry

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LER SUPPLEMENTAL INFORMATION

BFRO-50- 259 / 80031 RI Technical Specification involved 3.9.8, 3.6.F.1 & 3.4.A
Reported Under Technical Specification 6.7.2.b(2) * Date Due NRC
Date of Occurrence 4/15/80 Time of Occurrence 0714 Unit 1
Identification and Description of Occurrence:
During a 4kV shutdown bus 2 transfer a fault on the normal feeder bus from TS1B to 480-Vshutdown bd. 1B caused a loss of power to 480-VSD Bd 1B. Due to this loss of power 1B recirculation pump MG set tripped and 1B SLC pump became inoperable.
Conditions Prior to Occurrence:
Unit 1 @ 96%
Unit 2 @ 97%
Unit 3 @ 98%
Action specified in the Technical Specification Surveillance Requirements met due to inoperable equipment. Describe.
Board reenergized from alternate feed.
Apparent Cause of Occurrence:
Caused by fault condition at busway joint above the board. The apparent cause of the failure was a loose busway bolt.
Analysis of Occurrence:
There was no activity release, no personnel exposure or injury and no danger to health or safety of the public.
Corrective Action: The busway was replaced 7 days later with new busway. The busway bolts for 480-V shutdown boards 1A, 1B, 2A, 2B, 3A, and 3B were torque checked in accordance with EMI-78 and the bolts on board 1A were found to be loose. During subsequent refueling outages on unit 1 and 3 the busway bolts were torque checked and feeder bus meggered per EMI-78 and no problems were found.
NA Retention: Period - Lifetime; Responsibility - Document Control Supervisor
*Revision: Analyseu.